		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022541

Facility Name: CONTINENTAL CARE CENTER, INC.

Address: 5336 N. WESTERN AVE (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: 773-271-5600 **Fax #** 773-271-2144

IDPA ID Number: 36-2871756

Date of Initial License for Current Owners: 1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) ARTHUR M. ROTHBLATT, C.P. A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	208	Skilled (SNF)	208	76,128	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	208	TOTALS	208	76,128	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,559	2,104	6,523	31,186	8
9	SNF/PED					9
10	ICF	29,320	1,865	60	31,245	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,879	3,969	6,583	62,431	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.01%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 5,866

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/00 Fiscal Year: 12/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	265,821	25,752	13,754	305,327		305,327	18,887	324,214			1
2	Food Purchase		313,037		313,037	(32,720)	280,317	(199)	280,118			2
3	Housekeeping	173,378	45,357		218,735		218,735		218,735			3
4	Laundry	83,101	35,376		118,477		118,477		118,477			4
5	Heat and Other Utilities			144,694	144,694		144,694	1,627	146,321			5
6	Maintenance	78,153		102,403	180,556		180,556	2,958	183,514			6
7	Other (specify):*							1,519	1,519			7
8	**TOTAL General Services**	600,453	419,522	260,851	1,280,826	(32,720)	1,248,106	24,792	1,272,897			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	2,074,507	164,792	458,708	2,698,007		2,698,007	(33,374)	2,664,633			10
10a	Therapy	80,527	1,142	5,365	87,034		87,034	(814)	86,220			10a
11	Activities	61,131	11,998	2,392	75,521		75,521		75,521			11
12	Social Services	92,262		2,568	94,830		94,830		94,830			12
13	Nurse Aide Training											13
14	Program Transportation			1,444	1,444		1,444		1,444			14
15	Other (specify):*			225	225		225	5,049	5,274			15
16	**TOTAL Health Care and Programs**	2,308,427	177,932	475,502	2,961,861		2,961,861	(29,139)	2,932,722			16
	C. General Administration											
17	Administrative	135,036		583,242	718,278		718,278	(391,177)	327,101			17
18	Directors Fees											18
19	Professional Services			94,249	94,249	(328)	93,921	1,910	95,831			19
20	Dues, Fees, Subscriptions & Promotions			173,143	173,143		173,143	(91,274)	81,869			20
21	Clerical & General Office Expenses	166,769	67,543	147,347	381,659		381,659	42,347	424,006			21
22	Employee Benefits & Payroll Taxes			547,913	547,913	32,720	580,633		580,633			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,428	3,428		3,428	706	4,134			24
25	Other Admin. Staff Transportation							2,170	2,170			25
26	Insurance-Prop.Liab.Malpractice			119,760	119,760		119,760	86	119,846			26
27	Other (specify):*							35,813	35,813			27
28	**TOTAL General Administration**	301,805	67,543	1,669,082	2,038,430	32,392	2,070,822	(399,420)	1,671,403			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,210,685	664,997	2,405,435	6,281,117	(328)	6,280,789	(403,767)	5,877,022			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CONTINENTAL CARE CENTER, INC.
0022541
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	32,720	
2	FOOD		32,720

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	328	
19	PROFESSIONAL FEES		328

To reclass cost of appealing real estate taxes

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. #0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			140,948	140,948		140,948	29,472	170,420			30
31	Amortization of Pre-Op. & Org.			5,625	5,625		5,625		5,625			31
32	Interest			208,694	208,694		208,694	3,515	212,209			32
33	Real Estate Taxes			245,183	245,183	328	245,511		245,511			33
34	Rent-Facility & Grounds							14,096	14,096			34
35	Rent-Equipment & Vehicles			13,870	13,870		13,870	1,693	15,563			35
36	Other (specify):*											36
37	**TOTAL Ownership**			614,320	614,320	328	614,648	48,776	663,424			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	61,519	471,344	550,834	1,083,697		1,083,697	(101,600)	982,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,704	113,704		113,704		113,704			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	61,519	471,344	664,538	1,197,401		1,197,401	(101,600)	1,095,801			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,272,204	1,136,341	3,684,293	8,092,838		8,092,838	(456,591)	7,636,247			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,408	30		9
10	Interest and Other Investment Income	(3,143)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(358)	21		18
19	Entertainment	(1,225)	21		19
20	Contributions	(3,345)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,200)	21		24
25	Fund Raising, Advertising and Promotional	(44,601)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,800)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(25,410)	20		28
29	Other-Attach Schedule	(25,882)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (192,754)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(263,837)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (263,837)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (456,591)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CONTINENTAL CARE CENTER, INC.

ID# 0022541

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	VETERAN PHYSICIAN CHARGES	(440)	10	2
3	PAINTING AND DECORATING	(1,284)	6	3
4	MARKETING CONSULTANT	(21,684)	20	4
5	IL COUNCIL ON LTC POLITICAL CONTRIB	(359)	20	5
6	VOIDED CHECKS INCOME	(121)	21	6
7				7
8	LEGAL COSTS RELATED TO 1999	(1,986)	19	8
9	BRIAN CLOCH TRAVEL EXP	(8)	21	9
10				10
11				11
12				12
13				13
14				14
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16				16
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89				89
90	**Total**	(25,882)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				266	18,621							18,887	1
2	Food Purchase	(199)											(199)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,627									1,627	5
6	Maintenance	(1,284)		557	3,685								2,958	6
7	Other (specify):*				1,519								1,519	7
8	**TOTAL General Services**	(1,483)		2,184	5,470	18,621							24,792	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(440)		31,451		(64,385)							(33,374)	10
10a	Therapy							(814)					(814)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,049									5,049	15
16	**TOTAL Health Care and Programs**	(440)		36,500		(64,385)		(814)					(29,139)	16
	C. General Administration													
17	Administrative			(391,177)									(391,177)	17
18	Directors Fees													18
19	Professional Services	(1,986)		3,896									1,910	19
20	Fees, Subscriptions & Promotions	(95,399)		4,125									(91,274)	20
21	Clerical & General Office Expenses	(93,712)		136,058									42,347	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			706									706	24
25	Other Admin. Staff Transportation			2,170									2,170	25
26	Insurance-Prop.Liab.Malpractice			86									86	26
27	Other (specify):*			35,813									35,813	27
28	**TOTAL General Administration**	(191,097)		(208,323)									(399,420)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(193,019)		(169,639)	5,470	(45,764)		(814)					(403,767)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	3,408		26,064									29,472	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,143)		6,658									3,515	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			14,096									14,096	34
35	Rent-Equipment & Vehicles			1,693									1,693	35
36	Other (specify):*													36
37	**TOTAL Ownership**	265		48,511									48,776	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(15,059)		(86,541)					(101,600)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**					(15,059)		(86,541)					(101,600)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(192,754)		(121,128)	5,470	(60,823)		(87,355)					(456,591)	45

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,627	$ 1,627	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	557	557	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	31,451	31,451	17
18	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	5,049	5,049	18
19	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	5,688	5,688	19
20	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	22,830	22,830	20
21	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	22,007	22,007	21
22	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	55,189	55,189	22
23	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	6,004	6,004	23
24	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	2,470	2,470	24
25	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	17,877	17,877	25
26	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	3,896	3,896	26
27	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	4,125	4,125	27
28	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	136,058	136,058	28
29	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	706	706	29
30	V	25	OTHER ADMIN. STAFF TRANS.		QUALITY CARE MANAGEMENT	100.00%	2,170	2,170	30
31	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	86	86	31
32	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	35,813	35,813	32
33	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	26,064	26,064	33
34	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	6,658	6,658	34
35	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	14,096	14,096	35
36	V	35	EQUIPMENT RENTAL		QUALITY CARE MANAGEMENT	100.00%	1,693	1,693	36
37	V								37
38	V	17	CORPORATE ALLOCATION	523,242	QUALITY CARE MANAGEMENT	100.00%		(523,242)	38
39	Total			$ 523,242			$ 402,114	$ * (121,128)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED			SEE ATTACHED	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 2,360	QUALITY CARE MANAGEMENT	100.00%	$ 6,045	$ 3,685	15
16	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	970	970	16
17	V								17
18	V	1	DIETICIAN SALARIES	3,158	QUALITY CARE MANAGEMENT	100.00%	3,423	266	18
19	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	549	549	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,518			$ 10,987	$ * 5,470	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 23,812	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 8,753	$ (15,059)	15
16	V	10	MEDICAL SUPPLIES	72,366	QUALITY CARE MEDICAL SUPPLY	100.00%	7,981	(64,385)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	18,621	18,621	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,178			$ 35,355	$ * (60,823)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 4,815	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	$ 4,001	$ (814)	15
16	V	39	ANCILLARY REHAB	512,075	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	425,534	(86,541)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 516,890			$ 429,535	$ * (87,355)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DAVID MEISELS	ADMIN CONSULTA	ADMINISTRATIV	67.00	SEE ATTACHED	7.5	13.63	MGMT FEES	$ 60,000	17-3	1
2	BRUCHA TEITELBAUM		ADMINISTRATIV	2.00	SEE ATTACHED	0.9	2.25	ADMIN SAL	6,004	17-7	2
3											3
4	JOSEPH MEISELS		ADMINISTRATIV	2.00	SEE ATTACHED	3.5	6.98	ADMIN SAL	2,470	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 68,474		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	352,747	6	$ 9,193	$	62,431	$ 1,627	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	352,747	6	3,145		62,431	557	2
3	10	SAL-NURSING	PATIENT DAYS	352,747	6	177,703	177,703	62,431	31,451	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	352,747	6	28,527		62,431	5,049	4
5	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	352,747	6	32,137	32,137	62,431	5,688	5
6	17	ADMIN. SAL.- A. SALTZMAN	PATIENT DAYS	352,747	6	128,995	128,995	62,431	22,830	6
7	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	352,747	6	124,342	124,342	62,431	22,007	7
8	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	352,747	6	311,829	311,829	62,431	55,189	8
9	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	352,747	6	33,925	33,925	62,431	6,004	9
10	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	352,747	6	13,958	13,958	62,431	2,470	10
11	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	352,747	6	101,006	101,006	62,431	17,877	11
12	19	PROFESSIONAL FEES	PATIENT DAYS	352,747	6	22,013		62,431	3,896	12
13	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	352,747	6	23,307		62,431	4,125	13
14	21	CLERICAL & GENERAL	PATIENT DAYS	352,747	6	768,752	651,494	62,431	136,058	14
15	24	EDUCATION & SEMINAR	PATIENT DAYS	352,747	6	3,989		62,431	706	15
16	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	352,747	6	12,263		62,431	2,170	16
17	26	INSURANCE	PATIENT DAYS	352,747	6	485		62,431	86	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	352,747	6	202,353		62,431	35,813	18
19	30	DEPRECIATION	PATIENT DAYS	352,747	6	147,266		62,431	26,064	19
20	32	INTEREST	PATIENT DAYS	352,747	6	37,619		62,431	6,658	20
21	34	OFFICE RENT-UNRELATED	PATIENT DAYS	352,747	6	79,644		62,431	14,096	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	352,747	6	9,564		62,431	1,693	22
23										23
24										24
25	TOTALS					$ 2,272,015	$ 1,575,389		$ 402,114	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PAINTING REVENUE	21,912	5	$ 56,124	$ 56,124	2,360	$ 6,045	1
2	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	21,912	5	9,010		2,360	970	2
3										3
4	1	DIETICIAN SALARIES	DIETICIAN REVENUE	18,893	6	20,480	20,480	3,158	3,423	4
5	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	18,893	6	$ 3,288	$	3,158	$ 549	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 88,902	$ 76,604		$ 10,987	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Advanced Therapy & Rehab., L.L.C.
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						4,001	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						425,534	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 429,535	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CORUS BANK		X	MORTGAGE	VARIES	10/24/96	$ 1,200,000	$ 963,589	DEMAND	PRM+1%	$ 103,162	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	LINE OF CREDIT	INT ONLY	6/30/00	1,500,000	1,189,000	DEMAND	PRM+.5%	103,403	6
7	HILL ROM		X	EQUIP PURCHASE	$1,554.00	5/1/00	17,675	7,578	5/01/01	0.1000	781	7
8	BANK LEUMI		X	WORKING CAPITAL	VARIES	1/10/00		56,463	9/1/00	PRM+.5%	1,348	8
9	TOTAL Facility Related				$1,554.00		$ 2,717,675	$ 2,216,630			$ 208,694	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME										(3,143)	11
12	ALLOCATION QUALITY CA	X									6,658	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,515	14
15	TOTALS (line 9+line14)						$ 2,717,675	$ 2,216,630			$ 212,209	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	258,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	246,883	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,617)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	256,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	328	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 983 For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	245,511	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	266,805	8
	1996	273,370	9
	1997	265,995	10
	1998	248,551	11
	1999	246,883	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 4 : 2000 REAL ESTATE TAX ACCRUAL = $246882*1.04%=256800

LINE 6: Refund not offset since applies to a tax bill; not used to set a reimbursement rate

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,288 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: (1,875) 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 5,625 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		108,000	1976	$ 356,000	1
2					2
3	TOTALS	108,000		$ 356,000	3

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	208		1976	1976	$ 2,130,000	$ 60,857	35	$ 60,857	$	$ 1,247,550	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	6,105		20			6,105	9
10	Various			1980	9,032		20			9,032	10
11	Various			1983	19,029		20			19,029	11
12	Various			1985	24,698		20	985	985	17,704	12
13	Various			1986	43,755		20	2,188	2,188	26,689	13
14	Various			1987	31,019		20	245	245	28,931	14
15	Various			1988	12,294		20	137	137	11,038	15
16	Various			1989	27,060		20	985	985	17,304	16
17	Various			1991	19,303		20	965	965	9,074	17
18	Various			1992	2,934	293	20	293		2,491	18
19	Various			1993	11,866	637	20	594	(43)	4,612	19
20	Various			1994	38,563	2,094	20	2,094		13,472	20
21	Various			1995	54,419	2,923	20	2,721	(202)	16,338	21
22	PLUMBING WORK			1996	852	43	20	43		197	22
23	INSULATE PIPES			1996	1,437	72	20	72		318	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				137,266	5,885		10,122	4,237	10,194	32
33	PAGE 12C TOTALS				76,422	2,625		3,823	1,198	6,360	33
34	PAGE 12B TOTALS				181,027	9,078		9,051	(27)	22,289	34
35	PAGE 12A TOTALS				80,360	4,878		3,691	(1,187)	15,422	35
36	TOTAL (lines 4 thru 35)				$ 2,907,441	$ 89,385		$ 98,866	$ 9,481	$ 1,484,149	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPETING			1996	9,586	479	20	479		2,156	9
10	THERMO TECH			1996	1,650	83	20	83		415	10
11	PHONE SYSTEM			1996		547	20		(547)		11
12	WALLPAPER			1996	995	50	20	50		246	12
13	PUMP REPAIRS			1996	1,421	71	20	71		349	13
14	PUMP			1996	2,875	144	20	144		684	14
15	OFFICE CONSTRUCTION			1996	1,647	82	20	82		390	15
16	HOT WTR MOTOR			1996	1,095	55	20	55		248	16
17	CARPETING			1996	574	29	20	29		133	17
18	FIRE ALARM SYSTEM			1996	13,441		20	345	345	1,035	18
19	TELEPHONE			1996	422	42	20	21	(21)	100	19
20	OFFICE FAN UNIT			1996	598	30	20	30		143	20
21	PHONE SYSTEM			1996	1,454		20	73	73	219	21
22	CARPETING			1996	3,829	191	20	191		955	22
23	CUBICLE CURTAINS			1996	818	82	20	41	(41)	195	23
24	CUBICLE CURTAINS			1996	14,304	1,430	20	715	(715)	3,515	24
25	LIGHTS			1996	888	89	20	44	(45)	183	25
26	WTR HTR REPAIR			1996	752	38	20	38		158	26
27	Z.WALLACH CONSTRUCTI			1996	1,245	62	20	62		279	27
28	BLINDS			1996	2,486	249	20	124	(125)	517	28
29	SEWAGE PUMP REPAIR			1996	1,214	61	20	61		275	29
30	LIGHTS			1996	888	89	20	44	(45)	187	30
31	GENERATOR REPAIR			1996	1,306	131	20	65	(66)	265	31
32	ROOF REPAIR			1997	3,400	170	20	170		680	32
33	ELEVATOR RESTRICTOR			1997	2,800	140	20	140		443	33
34	FLOORING			1997	9,958	498	20	498		1,577	34
35	EXHAUST FAN MOLRS			1998	714	36	20	36		75	35
36	TOTAL (lines 4 thru 35)				$ 80,360	$ 4,878		$ 3,691	$ (1,187)	$ 15,422	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WIRING			1998	563	28	20	28		72	9
10	CHILLER			1998	89,800	4,490	20	4,490		11,973	10
11	WATERPROOFING			1998	12,900	645	20	645		1,344	11
12	INSULATE PIPES			1998	736	37	20	37		96	12
13	FIRE SYSTEM			1998	1,949		20	97	97	202	13
14	REHAB CLOSET			1998	942	47	20	47		118	14
15	WINDOWS			1998	2,010	101	20	101		236	15
16	FIRE DAMPER			1998	607	30	20	30		78	16
17	Z WALLACH			1998	2,436	122	20	122		254	17
18	EXHAUST SYSTEMS			1998	3,644	182	20	182		379	18
19	WIRING			1998	3,698	185	20	185		385	19
20	WIRING			1998	1,677	84	20	84		175	20
21	FIRE ALARM CALL SYS			1998		672	20		(672)		21
22	PAINTING & DECOR			1998	6,788		20	339	339	848	22
23	COUNTER TOP HINGES			1998	2,567		20	128	128	288	23
24	FIRE ALARM SYSTEM			1998	3,872	194	20	194		582	24
25	FIRE ALARM SYSTEM			1998		1,638	20		(1,638)		25
26	REPACK FIRE PUMP			1998	825		20	41	41	113	26
27	FIRE ALARM WIRING			1998	4,141	207	20	207		621	27
28	PUMP MOTOR			1998	1,232	62	20	62		186	28
29	WIRING			1998	1,007	50	20	50		150	29
30	EXHAUST FAN			1998	1,950	98	20	98		294	30
31	WATER METER			1998	1,797	90	20	90		233	31
32	FIRE ALARM SYSTEM			1998	32,750		20	1,638	1,638	3,276	32
33	FIRE DAMPERS			1998	1,200	60	20	60		145	33
34	WIRING			1998	1,128	56	20	56		168	34
35	HVAC-MOTOR & DISCONN			1999	808		20	40	40	73	35
36	TOTAL (lines 4 thru 35)				$ 181,027	$ 9,078		$ 9,051	$ (27)	$ 22,289	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR HINGE & REINFOR			1999	727		20	36	36	45	9
10	COOLING TOWER BEARIN			1999	1,575		20	79	79	138	10
11	LOCKS			1999	1,681	168	20	84	(84)	161	11
12	INSULATION BOILER			1999	1,297	65	20	65		119	12
13	INSTALL FLOORING			1999	1,847	92	20	92		146	13
14	THEROTECH			1999	2,657	133	20	133		200	14
15	DOOR ALARMS			1999	2,273		20	114	114	219	15
16	FIRE DAMPERS			1999	29,600	1,480	20	1,480		2,713	16
17	INSTALL SPRINKLER			1999	735		20	37	37	43	17
18	INFRARED DOOR DETECT			1999	4,300	215	20	215		340	18
19	INST.FUEL TANK 50%			1999	4,293	215	20	215		251	19
20	EXPLOSION PROOF BRAC			1999	1,072		20	54	54	95	20
21	PAINTING & DECORATIN			1999	7,683		20	384	384	576	21
22	REPLACE H20 PUMPSEAL			1999	576		20	29	29	48	22
23	CARPET & INSTALL			1999	2,088	104	20	104		191	23
24	REPAIR NURSE CALL SY			1999	843		20	42	42	67	24
25	REPLACE CONN.OVEN DO			1999	1,245		20	62	62	109	25
26	REPAIR COOLING TOWER			1999	1,165		20	58	58	97	26
27	REPAIR FIRE ALARM SY			1999	870		20	44	44	73	27
28	EJECTOR PUMP PARTS			1999	1,546		20	77	77	122	28
29	INSTALL DOOR CLOSER			1999	610		20	31	31	54	29
30	INSTALL DOOR HINGE			1999	2,730		20	137	137	160	30
31	MOTORIZED DAMPER			1999	1,498		20	75	75	106	31
32	REPAIR CALL SYST			1999	1,528	153	20	76	(77)	146	32
33	PATIO DOOR TEMPERED			1999	513		20	26	26	37	33
34	INSTALL HVAC PIPING			1999	550		20	28	28	35	34
35	INSTALL LIGHTS IN OX			1999	920		20	46	46	69	35
36	TOTAL (lines 4 thru 35)				$ 76,422	$ 2,625		$ 3,823	$ 1,198	$ 6,360	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	B & G BEARING ASSEMB			1999	698		20	35	35	58	9
10	LANDING GATES&HANDRA			1999	978	98	20	49	(49)	98	10
11	ELECTRIC WIRING			2000	1,695	50	20	23	(27)	23	11
12	II ACCESS DOORS			2000	1,986	116	20	397	281	397	12
13	ELECTRIC WIRING			2000	798	37	20	18	(19)	18	13
14	25 DOORS			2000	3,942	361	20	789	428	789	14
15	ELECTRICAL WIRING			2000	6,272	314	20	154	(160)	154	15
16	SATELLITE SYSTEM			2000	40,000	2,333	20	5,715	3,382	5,715	16
17	INSTALL PHONES			2000	743	74	20	106	32	106	17
18	FENCE			2000	511	21	20	26	5	26	18
19	ELECTRIC WIRING			2000	12,475	208	20	93	(115)	93	19
20	PAINTING AND DECORATING			2000	1,284		20	32	32	32	20
21	BLINDS			2000	662	44	20	133	89	133	21
22	INSTALL MIRROR			2000	1,957	49	20	392	343	392	22
23	BOILER HEAT EXCHANGE			2000	4,950	83	20	990	907	990	23
24	INSTALL BREAKER			2000	2,832	71	20	33	(38)	33	24
25	ELECTRIC REHAB ROOM			2000	1,650	14	20	5	(9)	5	25
26	REHAB ROOM			2000	1,392	18	20	8	(10)	8	26
27	WIRING KITCHEN			2000	769	6	20	3	(3)	3	27
28	ELECTRIC TRANSFER			2000	11,246	141	20	60	(81)	60	28
29	PUSH BUTTON LOCKS			2000	583	29	20	117	88	117	29
30	FIRE GUARD TANK			2000	6,381	186	20	89	(97)	89	30
31	FIRE DAMPERS			2000	31,000	1,550	20	762	(788)	762	31
32	REMOVE FUEL TANK			2000	2,462	82	20	93	11	93	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 137,266	$ 5,885		$ 10,122	$ 4,237	$ 10,194	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 553,164	$ 73,592	$ 63,412	$ (10,180)		$ 265,466	37
38	Current Year Purchases	32,568	1,918	6,025	4,107		6,025	38
39	Fully Depreciated Assets	542,649	2,117	2,117			542,649	39
40								40
41	TOTALS	$ 1,128,381	$ 77,627	$ 71,554	$ (6,073)		$ 814,140	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	USED VAN	1988	$ 3,000	$	$	$		$ 3,000	42
43	FACILITY	1982 FORD	1982	14,556					12,000	43
44	FACILITY	1986 VAN	1986	15,916					15,916	44
45										45
46	TOTALS			$ 33,472	$	$	$		$ 30,916	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,425,294	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 167,012	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 170,420	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,408	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,329,205	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	BUILDING ADDITION IN PR	$ 245,140	58
59			59
60			60
61		$ 245,140	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CONTINENTAL CARE CENTER, INC.
0022541
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
CONTINENTAL CARE CENTER, INC	468,724	47,842	54,967	7,125	250,198
QUALITY CARE MANAGEMENT	84,440	25,750	8,445	(17,305)	15,268
TOTALS	553,164	73,592	63,412	(10,180)	265,466

LINE 29: CURRENT YEAR

CONTINENTAL CARE CENTER, INC	30,355	1,604	5,943	4,339	5,943
QUALITY CARE MANAGEMENT	2,213	314	82	(232)	82
TOTALS	32,568	1,918	6,025	4,107	6,025

LINE 30: FULLY DEPRECIATED

CONTINENTAL CARE CENTER, INC	542,649	2,117	2,117		542,649
QUALITY CARE MANAGEMENT					
TOTALS	542,649	2,117	2,117		542,649

TOTALS (Should Tie to Totals on Page 13)

CONTINENTAL CARE CENTER, INC	1,041,728	51,563	63,027	11,464	798,790
QUALITY CARE MANAGEMENT	86,653	26,064	8,527	(17,537)	15,350
TOTALS	1,128,381	77,627	71,554	(6,073)	814,140

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		208		$			3
4	Additions							4
5	ALLOCATION QUALITY CARE MGT				14,096			5
6								6
7	TOTAL		208		$ 14,096 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 15,563 Description: COPIER $12435, WATER SYSTEM $1435- allocation Quality Care Mgmt $1693
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 17,281	$		$ 17,281	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,946			7,946	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			525,607			525,607	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				122,335		122,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						349,009		349,009	13
14	TOTAL			$		$ 550,834	$ 471,344		$ 1,022,178	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	19,443
2	Beds exp	27,789
3	Oxygen	72,494
4	tube exp	23,812
5	Respiratory therapy	184,371
6	radiology	5,598
7	lab	11,277
8	IV	4,225
9		
10		
		349,009

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	93,332		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,012,557		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,510		6
7	Other Prepaid Expenses	13,542		7
8	Accounts Receivable (owners or related parties)	421,069		8
9	Other(specify): See supplemental schedule	119,384		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,719,394	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	486,000		13
14	Buildings, at Historical Cost	2,130,000		14
15	Leasehold Improvements, at Historical Cos	581,739		15
16	Equipment, at Historical Cost	1,223,976		16
17	Accumulated Depreciation (book methods)	(2,335,011)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,875		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	245,140		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,333,719	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,053,113	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 933,549	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	93,262		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,603		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,206		31
32	Accrued Real Estate Taxes(Sch.IX-B)	256,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,300		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,580		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,408,300	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,196,579		39
40	Mortgage Payable	1,020,051		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,216,630	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,624,930	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,428,183	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,053,113	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. **#** 0022541 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	68,359	
Employee Advances	49,027	
Exchange	1,998	
	119,384	

OTHER CURRENT LIABILITIES:	Amount	Amount
Wage assignments	2,580	
	2,580	

OTHER NON CURRENT ASSETS:		
Construction In Progress	245,140	
Utility Deposit		
Loan Costs		
	245,140	

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,518,058	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,518,058	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	535,125	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(625,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (89,875)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,428,183	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CONTINENTAL CARE CENTER, INC #	0022541	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,518,058
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,518,058
Equity(Deficit) from Page 17 Col 1		1,428,183
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,428,183

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,750,836	1
2	Discounts and Allowances for all Levels	(1,697,665)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,053,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,120,824	6
7	Oxygen	148,913	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,269,737	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	191,977	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,111	19
20	Radiology and X-Ray	8,624	20
21	Other Medical Services	91,718	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 317,430	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,143	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,143	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	(15,518)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (15,518)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,627,963	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,280,826	31
32	Health Care	2,961,861	32
33	General Administration	2,038,430	33
	B. Capital Expense		
34	Ownership	614,320	34
	C. Ancillary Expense		
35	Special Cost Centers	1,083,697	35
36	Provider Participation Fee	113,704	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,092,838	40
41	**Income before Income Taxes (line 30 minus line 40)****	535,125	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 535,125	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONTINENTAL CARE CENTER, I # 0022541 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	1999 MEDICARE COST REPORT SETTLEMEMT	(16,622)
3	VOIDED CHECKS	121
4	REFUND 1994 REAL ESTATE TAX	983
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	(15,518)

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,974	2,171	$ 62,156	$ 28.63	1
2	Assistant Director of Nursing	914	1,036	22,437	21.66	2
3	Registered Nurses	31,705	37,987	786,855	20.71	3
4	Licensed Practical Nurses	24,344	27,279	432,524	15.86	4
5	Nurse Aides & Orderlies	83,899	89,102	733,879	8.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,223	3,267	61,519	18.83	7
8	Rehab/Therapy Aides	6,259	6,943	80,527	11.60	8
9	Activity Director	1,924	2,203	22,342	10.14	9
10	Activity Assistants	5,120	5,399	38,789	7.18	10
11	Social Service Workers	10,200	11,180	92,262	8.25	11
12	Dietician	2,014	2,520	38,223	15.17	12
13	Food Service Supervisor	31,237	33,060	227,599	6.88	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,225	4,915	78,153	15.90	17
18	Housekeepers	25,956	27,587	173,378	6.28	18
19	Laundry	12,559	13,205	83,101	6.29	19
20	Administrator	1,344	2,090	78,866	37.73	20
21	Assistant Administrator	1,006	2,415	52,510	21.74	21
22	Other Administrative	188	211	3,659	17.34	22
23	Office Manager					23
24	Clerical	16,188	15,924	166,769	10.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,435	2,514	36,656	14.58	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	265,714	291,008	$ 3,272,204 *	$ 11.24	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 13,754	1-3	35
36	Medical Director	96	4,800	9-3	36
37	Medical Records Consultant	96	4,000	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	209	7,320	10-3	39
40	Physical Therapy Consultant	48	2,160	10a-3	40
41	Occupational Therapy Consultant	63	2,855	10a-3	41
42	Respiratory Therapy Consultant	1	31	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	65	2,392	11-3	44
45	Social Service Consultant	52	2,318	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	815	$ 39,629		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,822	$ 317,329	10-3	50
51	Licensed Practical Nurses	1,444	55,441	10-3	51
52	Nurse Aides	3,018	75,412	10-3	52
53	TOTAL (lines 50 - 52)	11,283	$ 448,182		53

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MONICA RAMIREZ 3/1-12/31/00	ADMINISTRATOR	0	$ 70,154
KAREN FOGEL 5/1-8/24/00	ASSIST ADMIN	0	28,265
DIANE SCHMIDT 1/23-3/5/00	ADMINSTRATOR	0	8,710
CYNTHIA GRECEN 8/24-12/31/00	ASSIST ADMIN	0	17,231
STEPHANIE ODLE 1/23-2/27/00	ASSIST ADMIN	0	7,014
OTHER	ADMIN TRAINING	0	3,659
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,033

B. Administrative - Other

Description	Amount
DAVID MEISEL	$ 60,000
QUALITY CARE MGMT	8,174
QUALITY CARE MGMT. FEES	515,068
TOTAL (agree to Schedule V, line 17, col. 3)	$ 583,242
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMITMENT CONSULTING	A/R CONSULTANT	$ 11,995
IL. ASSOC. HC. FACIL.	LABOR NEGOTIATION	208
PERSONNEL PLANNERS	UNEMPL CNSLT	1,760
ECONOCARE	PURCHASE CNSLT	2,359
FR&R	ACCOUNTING	25,345
SEE ATTACHED	LEGAL SERV	49,581
JCHO CONSULTANT	ACCREDITATION	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 94,248

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,895
Unemployment Compensation Insurance	36,124
FICA Taxes	245,163
Employee Health Insurance	158,351
Employee Meals	32,720
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	4,560
OTHER EMPLOYEE BENEFITS	20,836
401K BENEFITS	14,242
UNION PENSION	17,865
LIFE INS	3,878
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,634

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	44,155
Health Care Worker Background Check	72
(Indicate # of checks performed 7)	
LICENSES, INSPECTION, PERMITS	2,734
DUES	8,335
CLASSIFIED ADV	25,793
ADVERTISING	44,601
YELLOW PAGES	25,410
ALLOCATION QUALITY CARE MGMT	4,125
Less: Public Relations Expense	(3,345)
Non-allowable advertising	(44,601)
Yellow page advertising	(25,410)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 81,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,429
ALLOCATION QUALITY CARE MGMT	706
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,135

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CONTINENTAL CARE CENTER, INC. # 0022541 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL ON LONG TERM CARE $8153**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,962** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **114,192**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **32,720** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%L14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw